

b. COUNTY Garrett

x Oakland.

ON A FARM? YES ☐ NO ☒

Year 59

Hours	Min.
-------	------

U.S.A.

4. MOTHER'S MAIDEN NAME
Rachel Shaffer

Oakland, Md.

INTERVAL BETWEEN
ONSET AND DEATH

o

b)

o

c)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

(State)

ADDRESS (Street, city or town, state)

DATE SIGNED _____

Oakland, Md.

(State)

24b REGISTRAR'S SIGNATURE

Johnson & Kraus

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5642

CERTIFICATE OF DEATH

Reg. Dist. No.

05636

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accident, Md</u>				c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Accident, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GLENN</u> Middle <u>SCOTT</u> Last <u>COLLIER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1907</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Harnedsville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Tarleton Collier</u>				14. MOTHER'S MAIDEN NAME <u>Ella Leslie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>191-10-7528</u>		17. INFORMANT Address <u>Mrs. Hazel Collier, Accident, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 58</u> to <u>May 1959</u> , that I last saw the deceased alive on <u>May 14</u> , 19 <u>59</u> , and that death occurred at <u>10</u> a. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold O. Kamons</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>R.D. Markleysburg, Pa. May 15</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD O. KAMONS</u>				<u>R.D. MARKLEYSBURG, PA.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison</u>		22d. LOCATION (City, town, or county) (State) <u>Addison, Somerset Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5643 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05637

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton R.F.D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) MAGGIE CUSTER		4. DATE OF DEATH 5/22/1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb, 20th. 1867
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New. Germany, Garrett CO. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Warnick		14. MOTHER'S MAIDEN NAME Mary McIntyre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elsie Custer, Barton, Md. (Rural)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-renal Disease DUE TO (c) 4 YEARS		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-22-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/1959	
22c. NAME OF CEMETERY OR CREMATORY New Germany Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County (Rural)	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHTORN		ADDRESS LONACONING, MD.	
24a. REC'D BY REGISTRAR MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. Pages 1 and 2 with the State Board of Health. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5644 CERTIFICATE OF DEATH

Reg. Dist. No. 05638

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 6 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home				d. STREET ADDRESS Kolberg Hill			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Christina Middle Whitefield Last Evans				4. DATE OF DEATH Month May Day 8 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1903	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work, for self and others				10b. KIND OF BUSINESS OR INDUSTRY Maryland.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Cam Whitefield				14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Chas. W. Butts Address Gormaniana, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Acute Myocardial Infarction DUE TO (b) Cerebral Hemorrhage with rt. sided DUE TO (c) Paralysis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Rheumatism (right) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 wks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1959 to May 8, 1959 , that I last saw the deceased alive on May 8, 1959 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph Calandrella M.D.				ADDRESS (Street, city or town, state) Kitzmillers, Md. DATE SIGNED May 13-59			
PHYSICIAN'S NAME (Type) Ralph Calandrella, M. D.				DATE SIGNED May 13-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/1959		22c. NAME OF CEMETERY OR CREMATORY Philo Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE MAY 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5643 CERTIFICATE OF DEATH

05639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Grant</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>20 Minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gorman</u>		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vernie</u> Middle <u>Catherine</u> Last <u>Hanlan</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1897</u>		9. AGE (In years last birthday) yrs. <u>62</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Newton Lloyd</u>				14. MOTHER'S MAIDEN NAME <u>Alberta Whistler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>228-28-6741</u>		17. INFORMANT Address <u>"Husband" Roy R. Hanlin Gorman, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Coma</u> <u>260 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitis</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-15-59</u> , to <u>5-15-59</u> , that I last saw the deceased alive on <u>5-15-59</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland Maryland</u> DATE SIGNED <u>15 May 59</u>			
PHYSICIAN'S NAME (Type) <u>Andrew E. Mance, M. D.,</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thomas, W.Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hance</u>				ADDRESS <u>Thomas, W. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hance</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5646 CERTIFICATE OF DEATH

Reg. Dist. No.

05640

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller		c. LENGTH OF STAY IN 1b 30 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION State St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Adrian Middle Metz Last		4. DATE OF DEATH May Month 23 Day 1959 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1983
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 7 Days 16 Hours 15 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Nebraska	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Metz		14. MOTHER'S MAIDEN NAME Adeline Kerns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Ella Metz-Kitzmiller, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Cerebral Hemorrhage with it's sequelae Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. Hypertension (b) Schizophrenia (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia			INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 23, 1959 to May 23, 1959 , that I last saw the deceased alive on May 23, 1959 , and that death occurred at 7:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Calandrella		DATE SIGNED May 23-59	
PHYSICIAN'S NAME (Type) RAHPH CALANDRELLA		ADDRESS (Street, city or town, state) Kitzmiller, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/59	22c. NAME OF CEMETERY OR CREMATORY Philos	22d. LOCATION (City, town, or county) (State) Westernport Md.
23. FUNERAL DIRECTOR'S SIGNATURE El. Boral		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

VS A15 (4)
15M 9/58

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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5647 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,	c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kitzmiller	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Michaels		4. DATE OF DEATH Month May Day 8 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1959
9. AGE (In years lost birthday) yrs. 13		IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Oakland, Maryland
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME John Richard Michaels	
14. MOTHER'S MAIDEN NAME Helen Louise Paugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs. John R. Michaels, Kitzmiller, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity & Congenital 754.5 DUE TO Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATELECTASIS (c) ATELECTASIS			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 7 , 19 59 , to May 8 , 19 59 , that I last saw the deceased alive on May 8 , 19 59 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Feaster, Jr.		DATE SIGNED 5-8-59	
PHYSICIAN'S NAME (Type) Dr. James H. Feaster, Jr.		Oakland, Maryland	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	22b. DATE THEREOF 5/9/1959	22c. NAME OF CEMETERY OR CREMATORY Tasker Cemetery	22d. LOCATION (City, town, or county) (State) near Vindex, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		24a. REC'D BY REGISTRAR DATE MAY 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Office of registration	
13. Name of hospital		14. Name of physician		15. Name of nurse		16. Name of attendant	
17. Name of undertaker		18. Name of funeral home		19. Name of cemetery		20. Name of church	
21. Name of family		22. Name of friends		23. Name of neighbors		24. Name of community	
25. Name of society		26. Name of association		27. Name of organization		28. Name of institution	
29. Name of school		30. Name of college		31. Name of university		32. Name of government	
33. Name of state		34. Name of county		35. Name of city		36. Name of town	
37. Name of village		38. Name of hamlet		39. Name of estate		40. Name of property	
41. Name of land		42. Name of building		43. Name of structure		44. Name of object	
45. Name of item		46. Name of article		47. Name of thing		48. Name of matter	
49. Name of substance		50. Name of material		51. Name of element		52. Name of force	
53. Name of power		54. Name of energy		55. Name of motion		56. Name of action	
57. Name of behavior		58. Name of conduct		59. Name of character		60. Name of quality	
61. Name of quantity		62. Name of number		63. Name of figure		64. Name of shape	
65. Name of color		66. Name of sound		67. Name of taste		68. Name of smell	
69. Name of touch		70. Name of feeling		71. Name of emotion		72. Name of passion	
73. Name of desire		74. Name of love		75. Name of hate		76. Name of anger	
77. Name of fear		78. Name of hope		79. Name of faith		80. Name of trust	
81. Name of confidence		82. Name of belief		83. Name of opinion		84. Name of view	
85. Name of judgment		86. Name of decision		87. Name of action		88. Name of deed	
89. Name of work		90. Name of labor		91. Name of effort		92. Name of struggle	
93. Name of battle		94. Name of fight		95. Name of war		96. Name of peace	
97. Name of harmony		98. Name of concord		99. Name of agreement		100. Name of treaty	

b. COUNTY Grant

ON A FARM?
YES ☐ NO ☒

Day 6, Year 1959

Hours	Min.
-------	------

U.S.A.

not known

Gorman, W. Va.

INTERVAL BETWEEN ONSET AND DEATH

16

Malnutrition - Vitamin Deficiency

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

8/19

Oakland Md

(State)

Arthur J. Kraus

MADE IN U.S.A.

FOR COMBAT

WALL BOMB

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05643

5643 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Hospital</u>				d. STREET ADDRESS <u>Third St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Edward</u> Middle <u>Sharps</u> Last				4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>58</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18-12-90</u>			
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Lewis Allen Sharps</u>				14. MOTHER'S MAIDEN NAME <u>Anna Squires</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 1 7/14/1918 9/22/1918</u>				16. SOCIAL SECURITY NO. <u>12-32-8338</u>		17. INFORMANT <u>John Sharps</u> Address <u>Third St. Oakland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> <u>4:30.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>77 minutes</u> <u>4 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-8-1952</u> , to <u>4-8-1959</u> , that I last saw the deceased alive on <u>4-8-1959</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>58 2-4 St. Oakland Md</u> DATE SIGNED <u>5/15/59</u>									
ACTUAL SIGNATURE <u>Gerald N. Minnich</u> M.D.				PHYSICIAN'S NAME (Type) <u>J. H. Feaster Sr. M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald N. Minnich</u> ADDRESS <u>Oakland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>			

100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

5650

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Rural c. LENGTH OF STAY IN 1b 15 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Thayers Motel, Route #219				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oakland Rural / d. STREET ADDRESS Thayers Motel, Route #219 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Regina Middle Elizabeth Last Thayer				4. DATE OF DEATH Month May Day 6 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1918	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Compton				14. MOTHER'S MAIDEN NAME Bertha Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-34-2051		17. INFORMANT Phillips Thayer R. D. Oakland, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Acute Hepatic failure secondary to fatty degeneration of the liver DUE TO Cerebral edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 18 hrs. DUE TO (c) 18 hrs.						INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.				DATE SIGNED 5-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/1959		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE MAY 18 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

MEDICAL CERTIFICATION

2

2

X

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M

1

HAWAIIAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3-1-73

1. NAME OF DECEASED _____		2. SEX _____	
3. AGE _____		4. RACE _____	
5. DATE OF BIRTH _____		6. PLACE OF BIRTH _____	
7. DATE OF DEATH _____		8. PLACE OF DEATH _____	
9. TIME OF DEATH _____		10. TIME OF EXAMINATION _____	
11. OCCUPATION _____		12. CAUSE OF DEATH _____	
13. MANNER OF DEATH _____		14. SIGNATURE OF EXAMINER _____	
15. SIGNATURE OF WITNESS _____		16. SIGNATURE OF REGISTRAR _____	
17. SIGNATURE OF CLERK _____		18. SIGNATURE OF JURY _____	
19. SIGNATURE OF JURY _____		20. SIGNATURE OF JURY _____	
21. SIGNATURE OF JURY _____		22. SIGNATURE OF JURY _____	
23. SIGNATURE OF JURY _____		24. SIGNATURE OF JURY _____	
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31. SIGNATURE OF JURY _____		32. SIGNATURE OF JURY _____	
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67. SIGNATURE OF JURY _____		68. SIGNATURE OF JURY _____	
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71. SIGNATURE OF JURY _____		72. SIGNATURE OF JURY _____	
73. SIGNATURE OF JURY _____		74. SIGNATURE OF JURY _____	
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77. SIGNATURE OF JURY _____		78. SIGNATURE OF JURY _____	
79. SIGNATURE OF JURY _____		80. SIGNATURE OF JURY _____	
81. SIGNATURE OF JURY _____		82. SIGNATURE OF JURY _____	
83. SIGNATURE OF JURY _____		84. SIGNATURE OF JURY _____	
85. SIGNATURE OF JURY _____		86. SIGNATURE OF JURY _____	
87. SIGNATURE OF JURY _____		88. SIGNATURE OF JURY _____	
89. SIGNATURE OF JURY _____		90. SIGNATURE OF JURY _____	
91. SIGNATURE OF JURY _____		92. SIGNATURE OF JURY _____	
93. SIGNATURE OF JURY _____		94. SIGNATURE OF JURY _____	
95. SIGNATURE OF JURY _____		96. SIGNATURE OF JURY _____	
97. SIGNATURE OF JURY _____		98. SIGNATURE OF JURY _____	
99. SIGNATURE OF JURY _____		100. SIGNATURE OF JURY _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5651

Reg. Dist. No. **05645**

1. PLACE OF DEATH a. COUNTY <u>Garrett County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>23 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Route Oakland, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julie</u> Middle <u>Ann</u> Last <u>Whitmer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/1873</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Moyer</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Hatterman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Joseph Smith Star Route, Oakland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture head left femur - Hydro Thorax</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell May 6</u>					
20c. TIME OF INJURY Hour <u>2</u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>May 6 19 59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Near Oakland Garrett, Md.</u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. I. Baumgartner</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. I. Baumgartner</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>May 30, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Gorman, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Keighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5252

COUNTY OF <u>ALLEGANY</u> CITY OF <u>UNION</u>		DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	
NAME OF DECEASED <u>JOHN J. SMITH</u> SEX <u>MALE</u>		AGE <u>45</u> YEARS DATE OF BIRTH <u>1905</u>	
PLACE OF BIRTH <u>NEW YORK</u> OCCUPATION <u>LABORER</u>		CAUSE OF DEATH <u>HEART DISEASE</u> MANNER OF DEATH <u>NATURAL</u>	
TIME OF DEATH <u>10:00 AM</u> PLACE OF DEATH <u>HOME</u>		SIGNATURE OF EXAMINER <u>[Signature]</u> TITLE <u>Medical Examiner</u>	
SIGNATURE OF NEXT OF KIN <u>[Signature]</u> TITLE <u>Next of Kin</u>		SIGNATURE OF WITNESS <u>[Signature]</u> TITLE <u>Witness</u>	
DATE OF CERTIFICATE <u>1950</u> TIME OF CERTIFICATE <u>10:00 AM</u>		PLACE OF CERTIFICATE <u>HOME</u> SIGNATURE OF DECEASED <u>[Signature]</u>	

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